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ABSTRACT

There is little attention in the literature to the dyad of the woman therapist and the man patient; as a result, the woman therapist is faced with a poverty of theoretical accounts upon which she can draw in her clinical work. Although analytically-oriented work must focus on individual histories rather than cultural internalizations, analysis of the meanings of power and sexuality for men and women is critical to understanding the dynamcis of the woman therapist-man patient dyad. The transference of man patient to woman therapist is characterized by an alteration in the relationship between power and authority; in this the woman therapist must negotiate a balance different from that of the male therapist. In the process of countertransference the woman therapist may respond to the erotic transference of her male patient with feelings of being threatened, guilt, and shame; she may feel frustrated at being cast as the bad mother; or she may transfer feelings about her father onto her patient. In the supervision process as well, little attention is paid to the dynamics of the woman therapist's work with male patients. Without a literature that specifically addresses these transference and countertransference issues in the female therapist-man patient dyad, the woman therapist is at a disadvantage in conceptualizing the treatment process. (MCF)

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TURNING THE TABLES: THE WOMAN THERAPIST AND THE MAN PATIENT

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In this paper, I ask the question "What happens when a woman psychotherapist or psychoanalyst sees a man patient?" and, in particular, "How is the transference and countertransference distinctive in this dyad?" I have chosen two strategies for constructing an answer. The first has been to listen to the accounts of women analysts, therapists, and trainees concerning their work with men patients. The second strategy has been to integrate these accounts with psychoanalytic and feminist theory so as to conceptualize what is distinctive about a man being a woman's patient.

The classic psychoanalytic position has been that the transference will unfold blind to the sex of the therapist or analyst. As Karme (1979) points out, resistance to the idea that there may be differences in the transference to men and to women therapists is in part motivated by a fear that any acknowledgement of the impact of reality aspects of the analyst would undermine the concept of transference. Lurking behind this argument, however, one can read a subtextual fear that women analysts might have certain advantages in the analysis of preoedipal material. Freud (1931), in fact, approached this dangerous territory in his paper "Female sexuality" in which he suggested that his women colleagues might be better able to analyze the preoedipal attachment of women patients to their mothers. Yet, the obvious corrollary that women might also have easier access to such material with men patients was not drawn, and the question of what is distinctive about the work of women analysts was ghettoized into questions concerning the woman patient. As a result, there is a virtual absence in the literature of attention to the dyad of the woman therapist and the man patient. Significantly, this theoretical inattention is paralled by reports by Abramowitz (1976, 1980, 1981) of a consistent under-representation of male

patients in the caseloads of women psychotherapists.

Schafer's (1981) conceptualization of the theory and practice of psychoanalysis as inter-related narrative activities provides a link between this theoretical inattention and the clinical work of women therapist or analysts with men patients. Because this dyad has been subsumed under the exemplary narrative of the male doctor-woman patient, the woman therapist is faced with a poverty of therotetical accounts upon which she can draw in her clinical work. Although analytically oriented work is fundamentally idiographic so that individual histories rather than cultural internalizations must be the primary focus, I will argue that nonetheless an analysis of the different and asymmetrical meanings of power and sexuality for men and women is critical to an understanding of the interaction between the woman therapist and the man patient.

Whereas Freud and his male progeny worked within the presumed social order in which men have authority over women, for a woman to assume the chair of the doctor, to be the interpeter and the voyeur of a man patient, is a counter-normative act from which a myriad of new meanings emerge.

Perhaps the most fundamental alteration concerns the relationship between power and sexuality. For men, power and sexuality are complementary: the powerful man is perceived as sexually desirable, and being sexually desirable both reflects and enhances men's sense of power. In contrast, for women, the relationship between power and sexuality is much more complicated and certainly not simply complementary. For women, sexuality is often equated with being the object of desire, and being powerful frequently means refusing to be regarded as a sexual object. Thus, when a woman assumes a professional role, she often either literally or metaphorically puts on a coat of authority which signals that she is not to be approached as a sexual object. The woman psychotherapist or psychoanalyst is, however, in the

unique position of having to simultaneously put on and take off the coat of authority in that she must while maintaining her position of authority invite her male patients to reveal their feelings about her.

The second theme that is distinctive for the woman therapist concerns fantasies about her availability deriving from associations with the nurturant and/or depriving mother. According to object relations theory, the child comes to have a separate sense of self through learning that the primary caretaker, which is usually the mother, is not always available. The father, in contrast, is originally perceived as a separate being and as having other roles that are independent of the interaction with the child. The paradox of the therapeutic relationship is that it is structured as a delicate balance between an interaction with the distant father and the intimacy and dependency first experienced with the mother. Because mothers and fathers in the traditional family play different roles in the process of separation-individuation, men and women as analysts or therapists negotiate this balance from different positions.

I will next briefly discuss a variety of themes that may characterize the transference of male patients to women therapists. The first theme concerns the fact that men patients come to women therapists with a different history of relationships to women than is the case for women patients. In order to achieve what is considered in our culture to be appropriate gender identification, boys must both repudiate the original intimacy with the mother and, as Greenson (1966) puts it, "dis-identify" with the mother. Stoller (1975) argues that because this process is conflictual, masculinity requires "ever-vigilant defenses against succumbing to the pull of merging again with mother," and that intimacy with women may therefore be experienced as a threat to such defenses. This suggests that women therapists may at

times be experienced by male patients as threats to masculinity itself. Furthermore, if masculine identity is predicated upon a dis-identification with the mother, we might then expect the processes of internalization to differ with a woman therapist.

The second aspect of the transference that is distinctive for the male patient with the woman therapist involves feelings about the authority of the woman therapist. Lewis (1971) has drawn attention to the shame-evoking aspects of the analytic or therapy relationship. The male patient must manage not only feelings of humiliation at revealing to another thoughts deemed unacceptable, but also the humiliation of being weak in front of one who should according to the dominant ideology be weaker than oneself. What happens then, when, as inevitably occurs in the therapy process, the male patient feels belittled by the woman therapist?

One solution to this problem for the male patient is to eroticize the relationship. Whereas the woman patient's erotic fantasies about her male therapist extend the male therapist's psychic power to the sexual sphere, for the male patient, the erotic transference can serve to alter in fantasy the structure of the relationship—to undo the shame evoking power of the woman therapist by restoring the man to a fantasized dominance in the sexual encounter. Although a woman's transference love for her male analyst may also include hostile feelings, the fact that in our culture sexual behavior is viewed as diminishing women and augmenting men conditions the possibility for men to channel agressive impulses through sexual content.

Countertransferentially, both men and women therapists experience some combination of pleasure and anxiety in response to their patients' erotic transferences. Nonetheless, the literature, focussing primarily on the male analyst and the woman patient has tended to view the erotic transference as a component of the positive transference and consequently to emphasize the

pleasurable aspects for the therapist of the patient's erotic transference. Because the erotic transference in men patients is frequently interwoven with aggression or desires to dethrone the woman as the authority figure, and because being the object of desire has a very different meaning for women than for men, women therapists' responses to the erotic transference of their male patients frequently include feelings of being threatened, guilty, and ashamed. This appears to be particularly true for women in training who expressed fears that their patients erotic feelings signalled their incapacity to become therapists. Furthermore, as male patients struggle with their own fears of losing control, it is not uncommon for women therapists to feel at times fearful. Since the fear may be in part of sexual violence, a concommitant fear of appearing paranoid or vain may inhibit discussing the situation with colleagues.

Concerning the erotic countertransference, most therapists experience such feelings at times accompanied by varying intensities of guilt. Yet, there is considerable evidence that a much smaller percentage of women clinicians engage in sexual activities with their patients than is the case for male therapists. One explanation is that women are more acculturated to having sexual feelings and not acting upon them. Searles (1959) suggests a connection between the asymmetrical incest barrier--that the mother-son incest barrier is especially rigorous in contrast to the more frequently violated father-daughter incest barrier--and the woman analysts's feeling-responses to her patients oedipal strivings: that both the woman analyst and her patient uphold the incest barrier in order to protect the man from a relationship historically rooted in infantile dependency. Several of the women that I have interviewed spontaneouly drew parallels between their handling of their male children's oedipal fantasies about them or of their

handling of their own erotic feelings towards their adolescent sons and their work with male patients.

Another countertransference theme concerns the frustration of being cast in the role of the bad mother. In several cases described to me, the treatment began with a negative maternal transference which makes the development of a working alliance difficult. It is as though for certain male patients, seeing a woman therapist acts as a stimulus for the development of an intense transference which may take off like a brushfire. As one woman analyst described her feelings about a male patient who during the first phase of the treatment would fill the sessions with his accusations of her: "It's like a baby having colic and you try to feed it and it turns its head away and it screams and you want to shake it."

The final set of countertransference feelings that I will mention concerns the transference of feelings by the woman therapist about her father onto her patient. De Beauvior (cited in Lewis, 1976) argues that whereas women are familiar to men from their infancy, men are for women profoundly the other. Several women reported feeling a lack of intuitive understanding about their male patients which can be experienced either as threatening or as intellectually challenging. This is further compounded by the under-representation of men in the caseloads of women. As one training analyst reported, when women candidates finally get their first male analysand, they often initially respond with delight at getting a man that can mask seeing the profound nature of the patient's disturbances.

I want to conclude with a few remarks about supervision. Goin and Kline (1976) report that less than three percent of supervision time is used to address therapists' feelings about their patients. Similarly, women therapists report virtually no attention in supervision to the particular dynamics of the work with male patients. Furthermore, for most women in

training, the majority of supervisors are male. Many people have noted the triangle which may occur between supervisor, therapist, and patient in which that which cannot be discussed in the treatment is subsequently enacted in the supervisory relationship. In the worst possible scenario, women have reported feeling squeezed between a male patient and a male supervisor both of whom are enacting erotic and hostile impulses towards her. Other concerns about supervision with male supervisors include feeling like the "odd person" in the relationship and feeling that one's concerns are either not taken seriously or are misunderstood.

In conclusion, without a literature that specifically addresses the distinctive transference and countertransference issues that may arise in the dyad of the woman therapist and the male patient, the woman therapist or analyst will be at a disadvantage in conceptualizing the process of treatment. In addition, the case of the woman therapist and the male patient provides a unique window both for understanding the experiences of women as they assume positions of power and for understanding the ways in which men's relationships to women are conditioned by a history of women caretakers. Thus, by integrating an analysis of the treatment process with an analysis of gender, not only do we open up the possibility of fulfilling Freud's hope that psychoanalysis might provide a foundation for the study of larger cultural issues, but, more practically, we can also begin to construct narrative accounts upon which women psychotherapists and psychoanalysts can draw in their work with men patients.

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